

Arizona Long Term Care System (ALTCS), Elderly and Physically Disabled (EPD) Actuarial Memorandum

I. Purpose

The purpose of this actuarial memorandum is to demonstrate that the Arizona Long Term Care System (ALTCS) Elderly and Physically Disabled (EPD) capitation rates were developed in compliance with 42 CFR 438.6(c). It is not intended for any other purpose.

The proposed capitation rates incorporate portions of Arizona Governor Brewer's plan to preserve the State's Medicaid program with reforms that will drive down costs by an estimated \$500 million in the State General Fund for the partial first year. The plan was approved by the Legislature as part of the FY 2012 budget adoption and is subject to Federal approval. Initiatives included in the Governor's Medicaid reform plan addressed in this memorandum include limited benefit changes and reductions in provider reimbursement rates.

II. Overview of Bid and Rate Setting Methodology

The contract year ending 2012 (CYE12) is the first year of a new cycle for the ALTCS contract. Therefore, the CYE12 rates are the rates awarded as part of the competitive bid process for the CYE12 Request for Proposal (RFP). The awarded rates were then updated for any program and/or fee schedule changes that were not included in the bid process as well as necessary mix change adjustments as mentioned below. These rates represent the twelve month contract period October 1, 2011, through September 30, 2012.

Prospective offerors were required to submit three separate bids: one for the medical component, one for the case management component, and one for the administrative component. For the medical component, AHCCCS' actuaries developed actuarially sound rate ranges for the CYE12 contract year to be used in the evaluation of the bids submitted. The rate ranges were published for use by the prospective offerors and represented the lower half, or midpoint to minimum, of the actuarially sound rate range. There were no limits imposed for the case management component and an eight percent maximum was enforced for the administrative component. For those rate cohorts for which the offerors were not required to bid (Prior Period Coverage (PPC) and Acute Care Only), AHCCCS' actuaries developed actuarially sound capitation rates.

Because CYE12 is classified as a rate development year rather than a rate update to the previously approved CYE11 capitation rates, as adjusted April 1, 2011, AHCCCS' actuaries developed a new base time period to compute CYE12 rates and ranges. Historical Medicaid managed care encounter data was used as the primary data source in development of the base time period. This encounter data was made

available to AHCCCS' actuaries via an extract that provides utilization and cost data, referred to as the "databook". The contract between AHCCCS and the contractors specifies that the contractors may cover additional services. Non-covered services were removed from the databook and excluded from rate development.

Other data sources used in setting the actuarially sound rates and ranges include health plan financial statements, program changes, anticipated AHCCCS Fee For Service rate changes including but not limited to those for nursing facility and home and community based services (HCBS), changes in HCBS placement, Center for Medicare and Medicaid Services (CMS) National Health Expenditure (NHE) Report estimates and Global Insight Prospective Hospital Market Basket Inflation Index (GI) information.

AHCCCS posted the encounter databook and other supplemental resources such as financial data, analysis of program changes, and enrollment information to its website in order to provide all prospective offerors with the data necessary to submit appropriate bids for CYE12.

Trend rates were calculated from the databook and other sources on a unit cost and/or utilization basis by category of service (COS) and a cap was applied to limit the negative and positive trends to a reasonable level. For more information on trends see Section IV Projected Trend Rates.

Ideally, the experience data should be analyzed by different rate cells which are comprised of members with similar risk characteristics. However, segregating the ALTCS population into different rate cells would lead to a statistical credibility problem due to the statewide disbursement of the relatively small membership base. The ALTCS program has three rate cells: a prospective rate, a prior period coverage (PPC) rate and an Acute Care Only rate. Capitation rates for the ALTCS population do not differ by gender and/or age, but do differ by Geographical Service Area (GSA).

The experience data includes only ALTCS Medicaid eligible expenses for ALTCS Medicaid eligible individuals, as well as reinsurance amounts. The Prior Period Coverage (PPC) rates are reconciled to a maximum 5% profit or loss.

The general ~~process in developing~~ process in developing the prospective rates involves trending the base data, adjusted for program changes, to the midpoint of the effective period, which is April 1, 2012, and applying the mix percentage. The next step involves adjustments for share of cost offsets and, if applicable, any program changes. Next is the deduction of the reinsurance offsets. Lastly, the projected case management, administrative expenses, risk/contingency and premium tax are added to the projected claim PMPMs to obtain the capitation rates. Each step is described in the sections below. There are also separate sections describing the PPC population and the Acute Care Only population.

III. Base Period Experience

AHCCCS used historical encounter data for the time period from October 1, 2007 through June 30, 2010. The data was reviewed and audited for accuracy, timeliness and completeness through encounter validation studies as well as studies comparing the encounter data to the contractors' financial statements. A final adjustment was to apply completion factors to the encounter data for the more recent years.

IV. Projected Trend Rates

The trend analysis includes both the financial and encounter data experiences. Financial data experience is from October 2007 through March 2011. Encounter data experience, as noted above, is from October 2007 through June 2010. The claim PMPMs were computed on a yearly basis and a trend factor was calculated. These encounter and financial trend factors were compared with trend rates from sources such as the changes to the State's fee-for-service (FFS) schedules and Contractor's subcontracted rates. The trend rates developed were used to bring the base encounter data to the effective midpoint of the contract year.

Inherent in the encounter and financial data are unit cost trends which incorporate Contractors' Coordination of Benefits (COB) activities. AHCCCS provides Contractors with verified commercial and Medicare coverage information for their members which Contractors utilize to ensure payments are not made for medical services that are covered by the other carriers. When Contractors make a payment to cover members' coinsurance, deductibles, or Medicaid-covered services that are not covered by the other carriers, they submit encounters containing these reduced amounts. From state fiscal year (SFY) 2008 through SFY 2010, encounter-reported COB cost avoidance grew by greater than 83%, from \$130 million in SFY 2008 to \$239 million in SFY 10. Additionally, ALTCS EPD Contractors cost-avoided more than \$108 million in additional claims for which the Contractor had no financial obligation after the private insurance or Medicare payment was made. Consequently no encounters were submitted to AHCCCS and thus those services are excluded from capitation expenditure projections completely. AHCCCS continues to emphasize the importance of COB activities.

As part of the Governor's Medicaid reform plan, and pursuant to Laws 2011, Chapter 31, AHCCCS is given the authority to reduce fee schedule rates for all providers up to 5%. Therefore, effective October 1, 2011, AHCCCS will reduce all provider reimbursement, with few exceptions, by 5%, including all payment ratios utilized for provider reimbursement (e.g., all Cost-to-Charge Ratios (CCRs), By Report Percentages (BR), etc.). The decreases are included in the trend amounts by category of service and in total are approximately \$47.5 million statewide. In addition, the historical cost trends were selected using past encounter data, Contractor financial statements, and changes to the FFS schedules over the last several years that are not reflected in the encounter data. Utilization trends for both the NF and HCBS components were based on encounter data experience. For the Acute Care component, the trends were developed using both the encounter data and financial information and future FFS schedule changes.

The trend rates used in projecting the claim costs, which include RFP rebase impacts as well as reductions to fee schedule rates, are identified in Table I.

Table I: Average Annual Trend Rate before Mix and SOC

Service Category	Combine
Nursing Facility	-3.3%
HCBS	-13.0%
Acute	-6.9%

Smoking Cessation

Starting October 1, 2008, in accordance with Laws 2008, Chapter 131, AHCCCS added coverage for eligible tobacco cessation products which include nicotine replacement therapy (NRT) and tobacco use medications for eligible Title XIX AHCCCS members who wish to stop tobacco use and who are enrolled in a tobacco cessation program offered by the Arizona Department of Health Services. This program has been effective for almost two years, therefore making it possible to review how actual experience matches up with the initial projections. The review is based on encounter utilization and costs data for CYE09, CYE10 and CYE11 (YTD). AHCCCS determined EPD members were utilizing services at a lesser extent than included in last year's projection. Based upon this review AHCCCS is decreasing the amount included for tobacco cessation products in the capitation rates. The statewide impact to the EPD program for CYE12 is a decrease of approximately \$13,000.

V. Projected Gross Claim PMPM

The contract period for CYE12 rates is October 1, 2011, through September 30, 2012, so the midpoint is April 1, 2012. The claims' PMPMs from the base data were trended to the midpoint of the CYE12 rate period.

VI. Mix Percentage

The CYE12 combined mix percentages are set using a combination of current placement percentages, program growth/saturation and the number of ALTCS members. These sources were reviewed by contractor and by county, over a 21-month period. The HCBS and NF placement percentages can be found in Table II.

Table II: Combined Mix Percentages Weighted

GSA	CYE11		CYE12		Difference HCBS Mix
	NF Mix	HCBS Mix	NF Mix	HCBS Mix	
GSA 40 (Pinal, Gila)	24.55%	75.45%	24.58%	75.42%	-0.03%
GSA 42 (LaPaz, Yuma)	40.65%	59.35%	39.91%	60.09%	0.74%
GSA 44 (Apache, Coconino, Mohave, Navajo)	33.30%	66.70%	32.56%	67.44%	0.74%
GSA 46 (Cochise, Graham, Greenlee)	39.30%	60.70%	38.60%	61.40%	0.70%
GSA 48 (Yavapai)	40.13%	59.87%	36.62%	63.38%	3.51%
GSA 50 (Pima, Santa Cruz)	33.40%	66.60%	32.86%	67.14%	0.54%
GSA 52 (Maricopa)	27.26%	72.74%	25.66%	74.34%	1.60%
Statewide	29.84%	70.16%	28.56%	71.44%	1.28%

VII. State Mandates, Court Ordered Programs, Program Changes and Other Changes

Inpatient Day Limit

As part of the Governor's Medicaid reform plan, effective October 1, 2011 AHCCCS will be limiting inpatient days to 25 days per the twelve month period of October 1 through September 30 each year for members age 21 and older. Exceptions to this limit include:

- Psychiatric stays;
- Burn diagnoses at a governmentally-operated hospital with a specialized burn unit in Maricopa County;
- Transplant stays at facilities with specialty contracts with AHCCCS, when paid as part of component pricing;
- Same day admit/discharge services; and
- Stays at IHS/638 facilities.

For adult members with Medicare, AHCCCS will continue to pay cost-sharing for Qualified Medicare Beneficiaries (QMB) when the 25 day limit is reached. AHCCCS will not pay cost-sharing for non-QMB Medicare members for days beyond the 25 day limit. The estimated statewide savings is approximately \$12.6 million.

Hospital Outliers

As part of the Governor's Medicaid reform plan, and pursuant to Laws 2011, Chapter 31, language authorizing inpatient outlier payments was eliminated and AHCCCS was provided the authority to establish reimbursement methodologies "notwithstanding any other law." AHCCCS chose to maintain an outlier payment methodology for one year – with modifications – effective October 1, 2011. Those modifications include:

- Increasing cost thresholds by 5 percent; and
- Reducing CCRs by a percentage equal to a hospital's increase to its charge master based on any/all increases since April 1, 2011.

The impact of these changes is a savings of approximately \$675,000 statewide.

Transportation

Reductions to transportation rates effective October 1, 2011, are included in the Governor's Medicaid reform plan and authorized in Laws 2011, Chapter 31. This brings the AHCCCS reimbursement of ADHS-regulated ambulance rates to 68.59% of the approved rates. In accordance with this legislation, ambulance rate increases approved by ADHS after July 1 annually will not be included in AHCCCS' October 1 fee schedule until the following year in order to provide AHCCCS predictability in expenditures. Since ADHS approved ambulance rate increases (as requested by providers) through July 1, 2011, the impact of this reduction is less than the full 5%, at 4.8% or \$466,000.

Reduction in Respite Hours

As part of the Governor's Medicaid reform plan, effective October 1, 2011, the number of respite hours for adults and children receiving ALTCS Services will be reduced from 720 to 600 hours per the twelve month period of October 1 through September 30 each year. The statewide impact of this change is a reduction of \$48,600.

Institution for Mental Disease (IMD) Waiver and In-Lieu of Services

Included in the base rates is funding for "in lieu of" services, substituting cost-effective alternative inpatient settings in place of more costly inpatient non-specialty hospital placements. State approved FFS rates at inpatient non-specialty hospitals are approximately 93.5% more expensive than those provided in alternative inpatient settings. The proposed capitation rates allow for the provision of services in alternative inpatient settings that are licensed by ADHS/ALS/OBHL, in lieu of services in an inpatient non-specialty hospital, thus no increase to cap rates is included.

Movement of High Cost Member and Change in Related Costs

The EPD program has one extremely high cost member due to a rare medical condition who, during CYE11, relocated from one GSA to another. In addition, AHCCCS added the pharmaceutical product used by this member to its specialty contract with Phoenix Children's Hospital and is now able to obtain this drug at 340B discounted pricing. The result of the discounted pricing is a reduction of approximately \$190,000 in pharmacy expense. The impact of the member's move, net of the pharmacy savings, is approximately \$802,000.

VIII. Projected Net Claim PMPM

The Nursing Facility and Home and Community Based Services projected gross claim PMPMs were adjusted for the mix percentages. The projected gross claims PMPMs were then discounted for the recipients' Share of Cost. The SOC component is fully reconciled with each Contractor. (The reinsurance offset is already included in the acute care component of the rates for the EPD population.)

IX. Case Management, Administrative Expenses and Risk Contingency

The Case Management rates represent those rates awarded as part of the CYE12 RFP process which are reduced 3.8% over CYE11 rates. The administrative expenses range from 2.6% to 7.4% of medical expenses plus case management. The risk contingency percentage remains the same as CYE11 at 1%.

X. Proposed Capitation Rates and Their Impacts

The proposed capitation rates for the EPD population equal the sum of the projected net claim PMPM (in Section VIII) and the projected case management, administrative expenses and risk contingency PMPM (in section IX) divided by one minus the two percent premium tax. Table III shows the proposed capitation rates for the EPD population statewide.

Table III: Statewide Projected Net Capitation PMPM EPD Combined

Service Category	Gross CYE11		Net CYE11 Rate	% Gross Change	% Net Change	Gross CYE12		Net CYE12 Rate
	Rate	Mix				Rate	Mix	
Nursing Facility	\$ 5,419.37	29.84%	\$ 1,617.14	-3.3%	-7.4%	\$ 5,241.35	28.56%	\$ 1,496.93
Share of Cost			\$ (249.40)		-9.9%			\$ (224.60)
Net Nursing Facility			\$ 1,367.74		-7.0%			\$ 1,272.33
Home and Community (HCBS)	\$ 1,608.95	70.16%	\$ 1,128.84	-13.0%	-11.4%	\$ 1,399.54	71.44%	\$ 999.83
Case Management			\$ 114.56		-3.8%			\$ 110.19
Acute Care			\$ 389.66		-6.9%			\$ 362.90
Administration			\$ 201.95		-19.4%			\$ 162.72
Risk Contingency			\$ 32.03		-3.5%			\$ 30.91
Premium Tax			\$ 66.02		-9.1%			\$ 59.98
Net Capitation PMPM			\$ 3,300.80		-9.1%			\$ 2,998.86

XI. Acute Care Only Members

As in prior years, for members who are only eligible for acute care services in the ALTCS program, Contractors will be paid the acute care component plus the case management and administrative components. Since the reinsurance policy is the same for these members as for the other ALTCS members, the same reinsurance offset is appropriate.

XII. Prior Period Coverage (PPC) Rates

PPC rates cover the period of time from the effective date of eligibility to the day a member is enrolled with the Contractor. PPC rates are reconciled to a five percent profit/loss corridor.

AHCCCS used the actual PPC cost and PPC enrollment data for CYE08, CYE09 and CYE10 as the base in the development of the CYE12 PPC rates. Historical trends were developed and reviewed for appropriateness. Due to the relatively short PPC time period, AHCCCS' actuaries analyzed the data by combining rate cohorts or geographic regions to enhance statistical credibility when needed.

XIII. Proposed Capitation Rates and Budget Impact

Table IV includes the net capitation rates on a statewide basis for all rate cells as well as the estimated budget impact based off of CYE12 projected member months. The adjustments impact contractors ranging from -13.1% to -5.0%. Appendix I shows EPD rates by geographical service area and Contractor.

Table IV: Proposed Capitation Rates and Budget Impact

Rate Cell	CYE12 Projected MMs	CYE11 Rate (4/1)	CYE12 Rate	Based on CYE12 Annualized Projected Member Months		Dollar Impact	Percentage Impact
				Estimated CYE11 Capitation	Estimated CYE12 Capitation		
EPD	306,539	\$ 3,300.80	\$ 2,998.86	\$ 1,011,825,310	\$ 919,268,798	\$ (92,556,512)	-9.1%
PPC	10,436	\$ 995.99	\$ 908.41	\$ 10,394,509	\$ 9,480,493	\$ (914,016)	-8.8%
Acute Only	4,629	\$ 553.03	\$ 514.15	\$ 2,559,705	\$ 2,379,749	\$ (179,957)	-7.0%
Total				\$ 1,024,779,524	\$ 931,129,040	\$ (93,650,485)	-9.1%

XIV. CMS Rate Setting Checklist

1. Overview of rate setting methodology

A.A.1.0: Overview of rate setting methodology

AHCCCS is performing a rebase from the previously approved contract year ending 2011 (CYE11) rates under 42 CFR 438.6(c). Please refer to Section II.

AA.1.1: Actuarial certification

Please refer to Section XV.

AA.1.2: Projection of expenditure

Please refer to Section XIII.

AA.1.3: Procurement, prior approval and rate setting

AHCCCS is operating under the Competitive Procurement contracting method.

AA.1.5: Risk contract

The contract is an at risk contract.

AA.1.6: Limit on payment to other providers

AHCCCS makes no additional payment to the providers, except for Disproportionate Share Hospital (DSH), Graduate Medical Education (GME) and Critical Access Hospitals. GME is paid in accordance with state plan. DSH and Critical Access Hospital payments are paid in accordance with Waiver Special Terms and Conditions. None of the additional payments to the providers were included in the capitation calculation.

AA.1.7: Rate modification

Please refer to Sections III, IV, VI, VII, VIII, XI, XII, and XIII.

2. Base Year Utilization and Cost Data

AA.2.0: Base year utilization and cost data

Please refer to Sections II, III and IV.

AA.2.1: Medicaid eligibles under the contract

There are dual eligibles.

AA.2.2: Spenddown

Not applicable, not covered under this contract.

AA.2.3: State plan services only

The contract between AHCCCS and the Contractors specifies that Contractors may cover additional services. Non-covered services were not included in the encounter data used to set the rates.

AA.2.4: Services that can be covered by a capitated entity out of contract savings.

Same as AA.2.3

3. Adjustments to the Base Year Data

AA.3.0 Adjustments to base year data

Please refer to Sections II, III, IV, V and VII.

AA.3.1 Benefit differences

Please refer to Section VII for benefit changes to inpatient hospital days for adults and respite changes for all members.

AA.3.2 Administrative cost allowance calculation

Please refer to Section IX.

AA.3.3 Special populations' adjustment

It is anticipated that the risk characteristics of this population will not change materially from the base period to the effective period of the capitation rates. Therefore, no adjustment was made.

AA.3.4 Eligibility Adjustments

No adjustment was made.

AA.3.5 DSH Payments

No DSH payment was included in the capitation development

AA.3.6 Third party Liability (TPL)

This is a contractual arrangement between AHCCCS and the Contractors.

AA.3.7 Copayments, coinsurance and deductible in the capitated rates

EPD members do not pay any copays, coinsurance or deductibles, but some do pay SOC. See Section VIII.

AA.3.8 Graduate Medical Education (GME)

The experience excludes any payment for GME.

AA.3.9 FQHC and RHC reimbursement

The experience excludes any additional payments that FQHCs may receive from the State.

AA.3.10 Medical cost/ trend inflation

Please refer to Section IV.

AA.3.11 Utilization adjustment

Other than trend, no specific adjustment was made to utilization.

AA.3.12 Utilization and cost assumptions

Not applicable, since actual experience was used.

AA.3.13 Post-eligibility treatment of income (PETI)

Not applicable, not required to consider PETI.

AA.3.14 Incomplete data adjustment.

The CYE10 encounter data was not fully complete. AHCCCS assumed the data was approximately 95% complete and applied the appropriate completion factor to complete the CYE10 data. The audited financial statements may include outstanding claim liabilities, which were audited and believed to be reasonable by AHCCCS auditors.

4. Establish Rate Category Groupings

AA.4.0: Establish rate category groupings

Please refer to Section II.

AA.4.1: Age

Please refer to Section II.

AA.4.2: Gender

Please refer to Section II.

AA.4.2: Locality/region

Please refer to Section II.

AA.4.2: Eligibility category

Please refer to Section II.

5. Data Smoothing, Special Populations and Catastrophic Claims

AA.5.0: Data smoothing

Please refer to Sections II, III and IV.

AA.5.1: Special populations and assessment of the data for distortions

Data was not adjusted for special populations.

AA.5.2: Cost-neutral data smoothing adjustments

There was no cost-neutral data smoothing adjustments

AA.5.3: Risk-adjustment

No risk adjustment methodology is currently in place for the EPD population.

6. Stop Loss, Reinsurance, or Risk-Sharing arrangements

AA.6.1: Commercial reinsurance

There is no commercial reinsurance.

AA.6.2: Simple stop loss program

AHCCCS has a reinsurance program. Please refer to Section VIII and XI.

AA.6.3: Risk corridor program

There are reconciliations for PPC, HCBS and SOC.

7. Incentive Arrangements

At this time there are no incentive arrangements.

XV. Actuarial Certification of the Capitation Rates

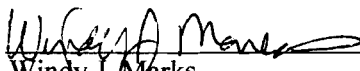
I, Windy J. Marks, am an employee of Arizona Health Care Cost Containment System (AHCCCS). I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time-to-time by the Actuarial Standards Board.

The rates were developed using generally accepted actuarial principles and practices and are considered to be actuarially sound. The rates were developed to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and are in accordance with applicable laws and regulations. The rates are appropriate for the Medicaid populations covered and Medicaid services to be furnished under the contract. The rates may not be appropriate for any other purpose. The documentation has been included with this certification. The actuarially sound capitation rates that are associated with this certification are effective for the twelve-month period beginning October 1, 2011.

The actuarially sound capitation rates are a projection of future events. It may be expected that actual experience will vary from the values in the rates.

In developing the actuarially sound capitation rates, I have relied upon data and information provided by the Program Contractors and the AHCCCS internal databases. I have accepted the data without audit and have relied upon the Program Contractors auditors and other AHCCCS employees for the accuracy of the data.

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.


Windy J. Marks


Date

Fellow of the Society of Actuaries
Member, American Academy of Actuaries

Appendix I

GSA	Contractor	EPD Rate	Acute Only Rate	PPG Rate
GSA 40 (Pinal, Gila)	Bridgeway	\$ 3,050.80	\$ 612.00	\$ 959.55
GSA 42 (LaPaz, Yuma)	Evercare	\$ 2,882.98	\$ 423.93	\$ 959.55
GSA 44 (Apache, Coconino, Mohave, Navajo)	Evercare	\$ 2,602.94	\$ 526.66	\$ 959.55
GSA 46 (Cochise, Graham, Greenlee)	Bridgeway	\$ 2,786.23	\$ 578.00	\$ 959.55
GSA 48 (Yavapai)	Evercare	\$ 3,075.52	\$ 485.64	\$ 959.55
GSA 50 (Pima, Santa Cruz)	Evercare	\$ 3,204.12	\$ 502.36	\$ 838.89
GSA 50 (Pima, Santa Cruz)	Mercy Care	\$ 3,148.03	\$ 451.16	\$ 838.89
GSA 52 (Maricopa)	Bridgeway	\$ 2,981.95	\$ 634.03	\$ 903.73
GSA 52 (Maricopa)	Evercare	\$ 3,323.83	\$ 359.12	\$ 903.73
GSA 52 (Maricopa)	Mercy Care	\$ 2,941.11	\$ 532.43	\$ 903.73
GSA 52 (Maricopa)	Scan	\$ 2,946.12	\$ 452.09	\$ 903.73